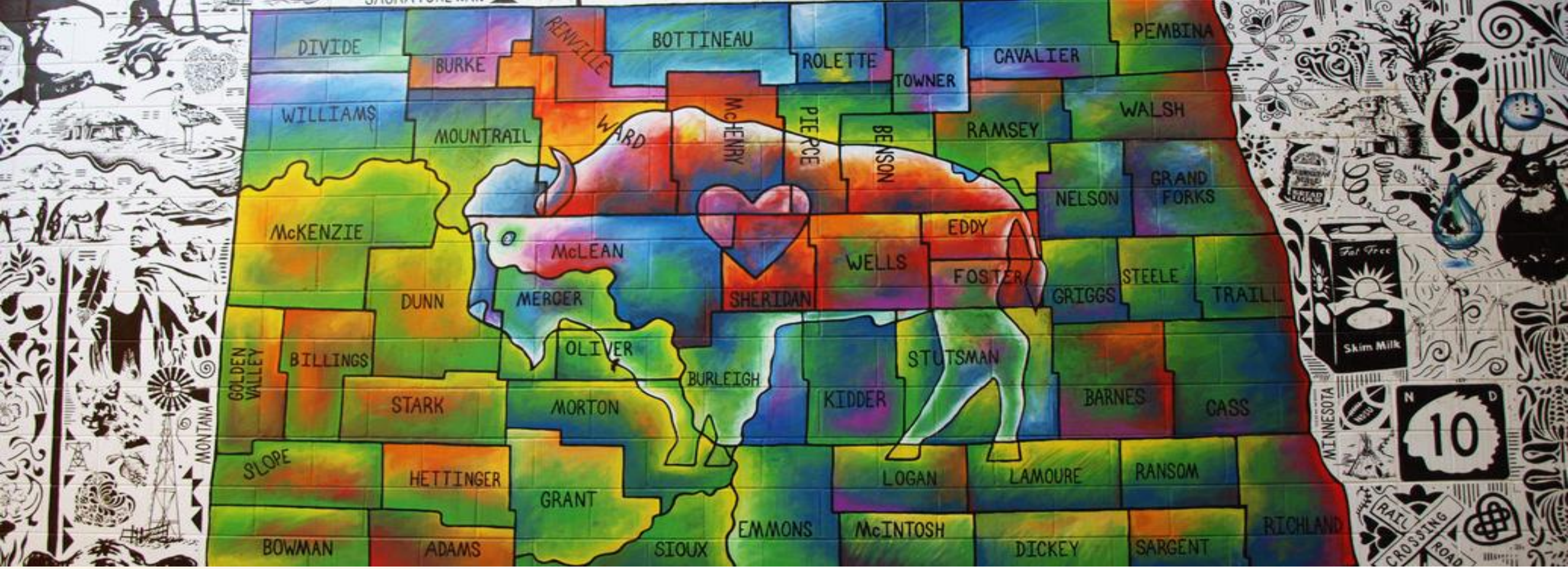


# Part I - 1915(i) Service Authorizations Medicaid Policy

NORTH Dakota | Human Services

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Revised 1/12/2022

# Presentation Overview

Part 1
1915(i) Policy and Procedural Components of Service Authorizations

# Traditional vs. Expansion

- As 1915(i) Providers, you will serve both Traditional Medicaid and Medicaid Expansion Members. This is included in the provider agreement you signed when enrolling as a 1915(i) Provider.
- The 1915(i) is available to both Traditional Medicaid and Medicaid Expansion members.
- Today's training is applicable to Traditional members.

# Medicaid Expansion Members

The Managed Care Organization (MCO) will provide policy and training applicable to Expansion Members.

Visit the 1915(i) website for contact information for the MCO to obtain further information on the 1915(i) for Expansion members.

# What is a Service Authorization Request?

- All 1915(i) services must be prior authorized by the SMA or the MCO. Providers will not be reimbursed for services provided prior to the service authorization approval date.

- Providers submit a Request for Service Authorization for each service to the SMA via MMIS for 1915(i) eligible Traditional members and to the MCO for 1915(i) eligible Expansion members.

# What is MMIS?

- MMIS is short for Medicaid Management Information System.

  A claims processing and information system that State Medicaid programs must have to be eligible for Federal Medicaid funding. The system controls Medicaid business functions, such as service authorizations, claims, and reporting. 1915i providers will enter all service authorizations and claims into MMIS.

# 1915i Service Authorization Process

- Following the development of the CC-POC, the care coordinator submits the completed POC and their service authorization request for the care coordination service via MMIS to the SMA for 1915(i) eligible Traditional members or to the MCO via their process for 1915(i) eligible Expansion members. The service authorization request must match the POC.

- The SMA or MCO approves or denies the CC-POC and service authorization. For Traditional members, MMIS generates a notification letter to the provider and to the individual. The denial letters contain client rights and appeals information. If denied, the care coordinator will make the necessary revisions to the service authorization request and resubmit.

- The Comprehensive Plan of Care Meeting (C-POC) meeting is held. Based on assessed needs and goals, the name, amount, frequency, and duration of each necessary service is documented in the C-POC, and the individual chooses a provider for each of the services.

- The care coordinator completes a Request for Service Provider form and sends to each identified provider.

# 1915i Service Authorization Process (cont.)

- Following acceptance from the provider of each of the requested services, the care coordinator enters the name of each provider on the C-POC, and forwards the final C-POC to all service providers.
- Upon receipt of the final C-POC, each provider submits their service authorization with the C-POC attached to via MMIS for 1915(i) eligible Traditional members and to the MCO via their process for 1915(i) eligible Expansion members.
- The SMA or MCO compares the service amount, frequency and duration of each service authorization request to the C-POC to ensure they match. The approval of the service authorization indicates approval of the C-POC.
- The SMA or MCO approves or denies the service authorization. The approval indicates C-POC approval as well. For Traditional members, MMIS generates a notification letter to the provider and to the individual. If the service authorization request doesn't match the C-POC, the request will be denied. If denied, the provider will make the necessary revisions to the service authorization request and resubmit.

# Key Points

- The Care Coordinator, in collaboration with the individual, determine the services, and amounts, frequency, and duration that each provider will request.
- The SA request must match the POC.
- The POC must be uploaded into MMIS along with the service authorization request.
- Providers will not be reimbursed for services provided prior to the service authorization approval date.

# Relevant Information

- One service authorization request per 1915(i) provider is required.
- Multiple 1915(i) services can be included on one service authorization request.
- The service authorization number must be on all provider claims.
- Only one service authorization number per claim is allowed.
- Service authorization approval also indicates POC approval.

# Service Authorization Requested Begin Date and Requested End Date for Traditional Medicaid Members

- **Requested Begin Date**: Providers will enter the anticipated start date of services. Service Authorization approval will be dated the actual date reviewed and approved, regardless of the requested begin date. Providers will not be reimbursed for services provided prior to the service authorization approval date.

- **Requested End Date**: The maximum time period a service authorization can be requested is to the end of the individual's 1915(i) eligibility period. The date of the end of the individual's 1915(i) eligibility period is obtained from the Zone.

(Contact the MCO for information pertaining to Expansion Members.)

# SA Approval or Denial Date for Traditional Members

- The SMA will use the date of the service authorization request submission as the approval or denial date.

- “Back-dating” of service authorization approval or denial dates is not allowed. The 1915(i) definition of “back-dating” is “*using an approval or denial date prior to the submission date of the service authorization”.*

- Providers who receive a service authorization request denial due to a submission error can resubmit the corrected service authorization request. The SMA will use the submission date of the original service authorization submission for the approval date.

(Contact the MCO for information pertaining to Expansion Members.)

# Notification of SA Approval or Denial for Traditional Members

- MMIS will generate the notification letter indicating approval or denial of the service authorization request. The notification letter is generated in the evenings and mailed to the provider and to the individual the next business day. Prior to receiving the mailed notification letter, providers have the option of checking the approval or denial status of the service authorization request in the web portal. If the web portal indicates a denial for the service authorization request, the provider will not see the reason for the denial in the web system. Instructions for checking status in the web portal is available in Part II of the Service Authorization Training Power Point available on the 1915(i) website.

(Contact the MCO for information pertaining to Expansion Members.)


# Service Limits, Rates, Codes

| Service Description | Age | Rate Type | Code & Modifier | Medicaid Fee/Rate | Service Limits | Remote Support/Tele-Communication Limits (Use Service Code 02) | Provider Type | Specialty Code | Group Taxonomy | Individual Taxonomy |
|---|---|---|---|---|---|---|---|---|---|---|
| Care Coordination - Coordinates participant care, develops Person-centered Plan of Care and assists individuals with gaining access to needed 1915(i) and other services. | 0+ | per 15 minutes | H2015 | $20.40 | 8 hours per day | 25% of Total Service in a Calendar Month. (Use Place of Service Code 02) | 049 | 641 | 251B00000X | 171M00000X |

View the entire chart at https://www.behavioralhealth.nd.gov/1915i

# Service Limits, Rates, Codes, etc.

# Service Description

Each service has a specific definition.  A provider will only be paid for those services delivered which fall within the scope/definition of the service.

If a Care Coordination provider decides to provide math tutoring to the member, they will not be reimbursed for that as it doesn't fall within the scope of the service.

# Age

Each 1915(i) service has age “limits” which identifies the ages of the individuals who can access the service.

# Rate Type per 15 minutes

Each service has one or more rate types associated with it.

The rate for the care coordination service is a unit rate of 15 minutes.

Other rate types include “per service”, or “dollar amount”.

# Code & Modifier

The “code” is referred to as the procedure code when entering service authorizations into MMIS.

- Each rate type within a service will have a code, and sometimes a modifier, associated with it. When there are multiple components to a service, each component will have its own code. For example, the Training and Supports for Unpaid Caregiver service is Code H0039 and Modifier UK for the 15 minute unit rate; and an additional Modifier “UA” must be added if the service is provided in a group setting. The rate code T2025 is for the “per service” component of the service.

The code for the Care Coordination service is H2015.

- There is no modifier for this service.

# Medicaid Fee/Rate

The Medicaid Fee/Rate for Care Coordination is $20.40 per 15 minute unit.

1 hour of service = $81.60 ($20.40 x four 15 minute units)

Each service has its own rate.

# Service Limits

The maximum limit for Care Coordination is 32 Units/8 hours per day.

Other services may have weekly, monthly, annual, or lifetime limits.

# Remote Support/Tele-Communications Limits

The majority of services allow remote service delivery with the established limits. *See Remote Support Service Delivery policy for additional requirements.*

Care Coordination Service may be delivered remotely up to 25% of the total services delivered in a calendar month.

# Provider Type

All 1915(i) providers use Provider Type 049.

# Specialty Code

Each service has its own Specialty Code.

# Group Taxonomy

Each service has its own group taxonomy assigned. Think of the Group Taxonomy code as the "Agency" Taxonomy code.

# Individual Taxonomy

Each type of individual provider has its own taxonomy assigned. The "Individual" Taxonomy Code represents the "employee/enrolled individual provider" who will provide the service.

Each Individual Provider must be affiliated with a Group Provider.

# NPI Number

All 1915(i) Group Providers and Individual Providers will obtain a National Provider ID (NPI).

# Electronic Visit Verification (EVV)

The 1915(i) Respite Service is subject to Federal EVV Regulations. The individual provider is required to check in and out to confirm their presence in the home.

Respite providers will submit service authorizations first in MMIS for the State's approval. After approval from the State, the Respite provider will enter a service authorization into Therap.

Therap will provide training to all 1915(i) Respite providers in the use of EVV and the Therap system.

See the Respite Service Policy for special instructions on the use of the Therap system for providers submitting service authorizations and claims for the respite service.

(Contact the MOC for their EVV process for Expansion members.)

# Place of Service Codes (POS)

- The POS Codes identify the location a provider delivers a service to a member.

- When submitting a service authorization request, the provider is required to identify the one POS code where they expect to deliver the majority of the services at. Later, when submitting the claim, the provider will list the correct POS code for each of the services they provided and are submitting a claim for reimbursement.

# Place of Service Codes

| Code | Name | Description |
|---|---|---|
| 02 | Telehealth | Services are provided or received through a telecommunication system. |
| 03 | School | A facility whose primary purpose is education. |
| 04 | Homeless Shelter | Location whose primary purpose is to provide temporary housing to homeless individuals. |
| 12 | Home | Location, other than a hospital or facility, where the member receives services in a private residence. |
| 18 | Place of Employment-Worksite | Location where the patient is employed. |
| 11 | Office | The provider's office. |

# For a complete list of POS Codes visit:

https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set

# Non-Standard Service Authorization Processes

# Non-Standard Service Authorization Processes

FOR TRADITIONAL MEDICAID MEMBERS

(SEE THE MCO WEBSITE FOR EXPANSION MEMBERS)

# Service Authorization Requests Exceeding the Limits

The only exception to requesting an amount of a service which exceeds the limit is:

> The additional service amounts are necessary to prevent the individual from being placed in a higher level of care, i.e. institution or other non-community-based setting.

ND Medicaid will review requests for service authorizations which exceed the maximum service limits.

The POC must clearly identify the needs of the member which require this additional amount of service.

The Service Authorization Process Flow available on the 1915(i) website shows the process the Care Coordinator and the Service Provider must follow for requests exceeding the maximum service limits.

# Changes to the Services in the POC

Whenever a service within the individual's POC changes, a new service authorization must be requested.

# Member's Traditional Medicaid Eligibility Changes to Medicaid Expansion

- If a member's Medicaid status changes from Traditional Medicaid to Expansion, the current service authorization is no longer valid. The care coordinator will submit the POC to the MCO, and the MCO's Service Authorization process will be implemented.

- Each provider on the POC will need to submit a new service authorization request to the MCO, using the MCO's process for Expansion members.

- See the Service Authorization Process Flow located on the 1915(i) Website for the steps necessary in the event a member's Traditional Medicaid changes to Medicaid Expansion.

# Member's Medicaid Expansion Eligibility Changes to Traditional Medicaid

- See the 1915(i) SA Policy and the Service Authorization Process Flow located on the 1915(i) Website for the steps necessary in the event a member's Medicaid Expansion eligibility changes to Traditional Medicaid.

- A new service authorization is needed.

# A Transfer From One Care Coordination Provider To Another

- See the 1915i SA Policy and the Service Authorization Process Flow located on the 1915(i) Website for the steps necessary in the event a member transfers from one care coordination provider to another.

- A new service authorization is needed.

# Member Transfers From One Service Provider To Another

- See the 1915i Policy and the Service Authorization Process Flow located on the 1915(i) Website for the steps necessary in the event a member transfers from one 1915(i) provider to another.

- A  new service authorization is needed.

# Member Placed in Non-Compliant Setting – 90 Day Exception

- If an eligible 1915(i) member is placed in a non-compliant setting, no services can be provided.
- However, a service authorization can remain valid for up to 90 days if an individual is placed in a non-HCBS setting/institution and is anticipated to return to the community within 90 days and resume 1915(i) services.
- Although no 1915(i) services can be provided during this 90-day time-frame, the individual will not need to go through the 1915(i) eligibility process again, and a new service authorization will not be needed providing no changes have occurred within the 90 days.

# Change in Living Arrangements – 1915(i) Closes

In the event a living arrangement change results in the member's 1915(i) eligibility ending, then the service authorization is no longer valid.

The Medicaid Living Arrangement Reference Hard Card is located here:

http://www.nd.gov/dhs/policymanuals/51003/51003.htm#510-03-105-10.htm%3FTocPath%3DEligibility%2520factors%2520for%2520ACA%2520Medicaid%2520510-03%7CReference%2520Hard%2520Cards%2520510-03-105%7C____2

If the individual is later determined eligible for the 1915(i) again, a new service authorization is required.

# Confirmation of Member Eligibility

It is the provider's responsibility to confirm 1915(i) eligibility prior to providing each service.

- For Traditional members, providers are to call the AVRS 1-877-328-7098 line to check individual member eligibility.
- For Expansion members, providers will use the MCO's process to confirm eligibility.

# Why Check for Member Eligibility?

- If 1915(i) eligibility ends, no services can be provided, and the service authorization is no longer valid.
- A service provided to someone who isn't 1915(i) eligible is not reimbursable.

# Traditional or Expansion Eligibility Verification

It is also the providers responsibility to know if the member is a Traditional or Expansion member prior to providing each service.

- If you submit a service authorization or claim for an Expansion member into MMIS, it will be rejected.
- If you submit a service authorization or claim for a Traditional member using the MCO's process, it will be rejected.

# Service Limits & Member's Medicaid Eligibility Change

1915(i) service limit maximums start over on the effective date of the individual's change from Traditional Medicaid to Expansion, and from Expansion to Traditional Medicaid.

# Documentation Requirements

ND Medicaid providers are required to keep records that thoroughly document the extent of services rendered to members and billed to ND Medicaid.

Records are used by ND Medicaid to determine the service was necessary and to verify that services were billed correctly.

# Documentation (Cont.)

- Medical records must be in their original or legally reproduced form, which may be electronic.
  - The department is not requiring you to use a certain system for your documentation.  Each provider is responsible for their own system and ensuring it meets these requirements.
- Documentation must support the time spent rendering a service for all time-based codes.

# Documentation (Cont.)

- Records must be retained for a minimum of six years from the date of its creation or the date when it was last in effect, whichever is later. State law may require a longer retention period for some provider types.

# Case File Documentation Must Be Maintained

- In a secure setting.
- On each individual in separate case files.

# Medical Record
# Valid Signature Requirements

For a signature to be valid, the following criteria is needed:

- Services that are provided must be authenticated by the author.
- Signatures shall be handwritten or an electronic signature. For additional guidance, CMS signature requirements can be found here:
  - https://med.noridianmedicare.com/web/jfb/cert-reviews/signature-requirements. *Note: This link does not work if using Internet Explorer.*
- Signatures are legible.
- Signature is dated and timed.

# Confidentiality and Access to Member Records

All Medicaid member, applicant information, and related medical records are confidential.

Providers are responsible for maintaining confidentiality of protected health information subject to applicable laws.

# Confidentiality

- Providers are required to permit ND Medicaid personnel, or authorized agents, access to all information concerning any services that may be covered by Medicaid. This access does not require an authorization from the member because the purpose for the disclosure is to carry out treatment, payment or healthcare operations permitted under the HIPAA Privacy rule under 45 CFR §164.506.

- Notice that ND Medicaid and health plans contracting with ND Medicaid (i.e. MCO for Expansion members) must be allowed access to all information concerning services that may be covered by Medicaid. This access does not require an authorization from the member.

- Health plans contracting with ND Medicaid must be permitted access to all information relating to Medicaid services reimbursed by the health plan.

# Resources

- Service Authorization Process Flow is located on the 1915(i) website:
  - https://www.behavioralhealth.nd.gov/1915i
- The 1915(i) is an amendment to the ND Medicaid State plan; thus, all ND Medicaid State Plan Provider-related Billing and Claims policies and regulations also pertain to the 1915(i). Further information is available in the General Provider Manual:
  - http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/general-information-medicaid-provider-manual.pdf